(b) The board recommended adoption of a subcommittee report on medical libraries, which proposed that the Association contribute $1 per active member per year, to be divided between the Stanford Lane and the Los Angeles County Medical Association libraries and also that a technical committee consisting of named members be established to develop a technical program for comprehensive medical library service for members of the Association.

ACTION: Voted to refer subject of financial support of medical libraries to an ad hoc committee of the Council.

(c) The board recommended that the Association become a co-sponsor for a follow-up conference in California to the Second National Conference on Cardiovascular Diseases, that $800 be allocated to the support of the conference and that component societies be urged to participate and encourage attendance. A substitute motion which would have removed the Association from co-sponsorship and financial support was discussed but defeated by vote.

ACTION: Voted to co-sponsor follow-up conference in California to Second National Congress on Cardiovascular Disease, to contribute $800 toward the conference and to encourage component societies to encourage participation and attendance.

24. *Commission on Allied Health Services*

The chairman read a letter from a member in Napa County, in which complaint was made against radio announcements which were considered as over-commendatory to a professional group of lesser training than physicians.

ACTION: Letter referred to Commission on Allied Health Services.

Time and Place of Next Meeting

The chairman announced that the next meeting would be held at the Airport Marina Hotel, Los Angeles, on Saturday, August 7, 1965.

Adjournment

There being no further business to come before it, the meeting was adjourned at 4:35 p.m. in the memory of Doctors Junius B. Harris and William J. Kerr.

CARL E. ANDERSON, M.D., *Chairman*
MATTHEW N. HOSMER, M.D., *Secretary*

State Fee Schedules

Following is the report of the California Medical Association Ad Hoc Committee on State Fee Schedules:

Introduction

The 1964 House of Delegates adopted a Resolution which directed the Speaker to appoint this ad hoc Committee, and established its assignments and authority. In review, these were as follows:

That the Legislative and Executive branches of the State of California be immediately notified that:

(1) The *Schedule of Maximum Allowances for Medical and Related Services for the State of California* is not acceptable to the California Medical Association;

(2) The branches of the government of the State of California purchasing medical care should compensate physicians on the basis of the current *Relative Value Studies;*

(3) The fees paid by the State should reflect the usual and customary fees for medical services; and

(4) The Committee be empowered to negotiate with the appropriate State officials to achieve these goals.

The Committee held its first meeting in July of 1964 and since has held eight general meetings and four subcommittee meetings, where nearly 100 per cent attendance was maintained.

We invited as our guests the following representatives of the State government:

Mr. Leslie Waight, Medical Fee Analyst of the State Department of Finance, members of his Technical Advisory Committee and related State officials including Messrs. Carel Mulder, State Department of Social Welfare; Gene Zelle and Richard Young, M.D., of the Department of Vocational Rehabilitation; Charles R. Gardipee, Jr., M.D. of the Crippled Children Services, State Department of Public Health; Mr. Ed Beach, Chief of the Budget Division, State Department of Finance and Mr. Alan Post, Legislative Analyst.

We also had as our guests Mr. Ben Read and staff of the Public Health League; Dan O. Kilroy,

M.D. and members of his Legislative Committee; Mr. Gene Potloff, Director of the California Physicians' Service Department of Research; and Doctors James C. Doyle, President, Ralph C. Teall, President-Elect and Carl E. Anderson, Chairman of the Council.

Conclusions and Recommendations

It is apparent that much of the year's activities of this Committee concerned the accumulation of data, opinions and experience. Certain improvements in the mechanism of the *Schedule of Maximum Allowances for Medical and Related Services for the State of California* seem quite possible and some hope of achieving proper representation on the Technical Advisory Committee of the Medical Fee Analyst seems appropriate. The recurrent frustrations involved in our efforts to achieve a more appropriate, higher level of fees and eventually a usual and customary fee system were neither new nor unexpected. Having experienced and evaluated their sources and causes, we are now in a position to present our interim conclusions and make recommendations for continuing efforts to achieve this major goal.

A review of the primary points covered in our discussions follows this section. Based on our discussions and conclusions, your ad hoc Committee recommends the following:

1. The CMA make known to the citizens of this State its position on medical care for all and its willingness to cooperate with all parties as spelled out in the 1964 House of Delegates Resolution No. 16-64.
2. The State Department of Finance be requested to accept and utilize in unabridged form, each current edition of the *Relative Value Studies* as the format for any system of payment.
3. The State Department of Finance be urged to accept the principle of variable conversion factors applied to separate sections of the *Relative Value Studies* when factors different from the statewide medians are used, and that monies now available to purchase medical care for recipients of State assistance be so applied to the current *Relative Value Studies.*
4. The State Department of Finance be urged to honor the concept that the State should purchase medical care for its recipients of State assistance on the same basis as is available to the public generally, and that, *as a step in this direction,* plans should be made to upgrade the level of fees paid to physicians to the level of the statewide median.
5. The State Department of Finance be urged to accept as its ultimate obligation the payment of usual and customary fees for professional services in accordance with the definition of usual and customary as adopted by the House of Delegates in 1964 (Resolution No. 21-64).
6. The Legislature, Department of Finance and State agencies be informed of the experience of the physician-sponsored prepaid medical care insurance program utilizing the usual and customary fee concept, and be urged to use similar insurance mechanisms in paying for medical care for recipients of State assistance when adequate funds become available to reflect the usual and customary fees.
7. The State Department of Finance be requested to have appointed to its Technical Advisory Committee to the Medical Fee Analyst, a minimum of four members selected from a list of names provided by CMA.
8. The CMA recognizes its responsibility to the people of California to (a) assist in the development and implementation of properly conceived and properly devised State medical care programs when the goal is to assure continuing high quality medical care to recipients of State assistance, and (b) to endorse and support those programs designed to assist those individuals in proven need of State assistance.
9. All State agencies administering medical care programs, the Department of Finance, and the Legislature be offered the continuing assistance of the Committee on Fees as consultants and advisors in all things pertaining or related to medical fees.
10. The Legislature be properly informed of our concern regarding quality, availability and economics of care being provided recipients of State assistance along with our appraisal of those factors causing breakdown in their programs, including recommendations for correction.
11. Full cooperation with the Legislature in studying these matters be authorized including use of statistical data available through present or past CMA studies when such data is essential to proper study and decision.
12. The Council be requested to instruct the Communications staff to make known the essence of this report and its recommendations to the membership in general by methods approved by this Committee.
13. Each member of CMA be advised of the progress made by this Committee and its predecessors, and determine for himself whether or not he wishes to participate in any of the State programs.
14. All Commissions and Committees of the Association be directed to adhere to these principles when approaching the State on matters of medical fees so that this House can be assured of continuity of these precepts.
15. This ad hoc Committee be continued, with instructions to press as hard as feasible in their negotiations for the acceptance of these recommendations by the appropriate State bodies.

Discussion

The early meetings were devoted to in-depth exploration of the designated functions and powers of the Committee and to the clear cut delineation of those CMA goals we were to implement. These goals were refined into their integral parts, and pro and con arguments surrounding them were ex-

plored. Even though the members of the Committee had been chosen for their previous experience in this field and even though the basic concepts were known, these deliberations proved the need for detailed discussion, careful planning, and careful coordination if the legitimate variations of viewpoint within the Committee, the activities of other CMA committees and the innumerable extrinsic factors were to be properly recognized and combined into an effective overall CMA plan of action.

It was immediately apparent that both our mandate from this House of Delegates and our own consensus demanded that our basic, constant long-range goal was to be the achievement of a system of payment of usual and customary fees for services provided by the physicians of California to recipients of State assistance. This system seeks to assure the care of these patients in the mainstream of high quality medical care side by side with our other patients for fees equal to those usually charged by the treating physician, recognizing, the legitimate variations in fees customary in the community in which the services are rendered. This goal specifically denies the propriety of any single, rigid schedule of fees at any level, including statewide or even regional median levels.

The second obvious goal was the use of the unadulterated, unabridged, current CMA Relative Value Studies as the basis for any system of payment and communication used by the State in these programs. Establishment of the *RVS* as the basic mechanism would assure equitable distribution of whatever funds were available during the interval period necessary to the development of the usual and customary fee system. In addition, a seldom emphasized but important benefit arising from use of the *RVS* would be its advantages as a means of communication of the nature and method of treatment involved. The broad scope of the listings, the nomenclature, the detailed definition of services and the ground rules of the *RVS* have been developed by physicians to describe services physicians provide. Establishment of the unabridged *RVS* as the basic mechanism would provide a proper and uniform means of communication between physicians and the State agencies even after a single fee schedule was discarded in favor of the usual and customary fee system. And, finally, the *RVS* would provide an underwriting mechanism of proven worth through which the State could determine its budgetary needs.

A subsidiary point of agreement in our early deliberations covering the use of the *RVS,* concerns the need for variable dollar conversion factors for each of the sections of the *RVS* when any but the statewide median conversion factors are used. This technical point deserves considerable attention in the interest of equity between physicians so long as the State insists on a rigid fee schedule, particularly a substandard rigid fee schedule such as is presently used.

There was general and ready agreement as to the above three points (usual and customary fees, *RVS* as the basis of payment and variable dollar conversion factors). Initially, there was considerable divergence of opinion as to the methods and sequences to be employed in the achievement of these goals. As our meetings widened to include various involved State officials, these divergencies tended to narrow. Under the pressures of hard facts of State administrative philosophies, budgetary limitations and expectations, it became clear that although certain accommodations were inevitable, a unified front in all approaches to the State on these matters was essential in achieving final success. It also became clear that success would come slowly and in steps rather than through one bold stroke.

The first meeting with the State agency personnel included the Medical Fee Analyst and his Technical Advisory Committee made up of various medical administrators from the agencies. These are the administrators responsible for the development of the present *Schedule of Maximum Allowances for Medical and Related Services for the State of California,* and the ones with whom the previous ad hoc Committee of the CMA Council had dealt. The discussions were frank and productive.

The Medical Fee Analyst outlined his duties, prerogatives and limitations. It is important that members of the medical profession fully realize that the State administrators cannot negotiate. They come only to seek information and advice in their attempt to devise systems which will evoke sufficient cooperation from the medical profession to accomplish the purposes of the programs as they see them. They attempt to reconcile these findings with the mandate and budgets provided by the Legislature and the pressures exerted by individual legislators. Further, it would be safe to say that, in spite of the negotiating role provided this ad hoc Committee by the House of

Delegates, the Committee actually lacks all of the tools of negotiation since it cannot, nor does it desire to, enforce its decisions on either the constituent societies or the individual members of CMA. It is obvious that under these circumstances, any conclusions or understandings reached between representatives of the State and your representatives have neither the aura nor the power of negotiated commitment. The State will make the final decisions and the State is free to change these decisions at will. When its decisions are incompatible with our goals, our only recourse is public exposure of the inadequacies and dangers of the system devised.

Your representatives in these discussions have but two sources of power. The first is, of course, the support and persuasive power of the CMA with its constitutent societies and its members. The second is the presentation of such clear-cut, unassailable and consistent arguments in support of our contentions that those making decisions at all levels of the State government will recognize the need to consider and include our recommendations in their planning if their programs are to achieve the medical goals we all seek.

Over and over the point was made that in the final analysis, the medical success of the State medical care programs can come only through physicians. The programs can provide funds, but cannot provide services. It is clear that the Legislative intent is to make available to recipients of State assistance the same high quality of medical care that is available to all California residents and it is the administrators' responsibility to provide an environment in which physicians can accomplish this common purpose. It is our contention that increasing administrative demands, the *Schedule of Maximum Allowances for Medical and Related Services for the State of California* and the low level of fees, are adversely affecting physician participation in these programs. Whenever and wherever State administrative decisions discourage physician participation in the programs, the quality and availability of medical care are seriously affected.

These theses were supported by a thorough discussion of the purposes, methods and general acceptance of the *RVS* by physicians and other private and public administrators. State administrators expressed the opinion that they have done a good, if not absolutely complete job of basing their schedule on the 1960 *RVS*. They felt that the changes they have made were not only minor but were essential for administrative purposes because of budgetary limitations. Their lack of detailed knowledge in the field in which they were making the final decisions is epitomized by the amazement expressed when it was pointed out that the *Schedule of Maximum Allowances for Medical and Related Services for the State of California* includes well over 700 changes in nomenclature, ground rules and values from the *1960 Relative Value Studies*. These changes are so significant as to seriously impair the usefulness of their efforts. It was pointed out also that CPS and others have found it possible to administer prepaid programs based on the unadulterated *RVS* even though some change in the previous administrative methods were required to accomplish this purpose. It was made clear that even though budgetary limits were recognized, the method employed to reconcile these to the *RVS* by the Technical Advisory Committee had been incorrect and completely destroyed relativity in large sections of the *RVS*. The need for variable conversion factors in their substandard schedule was emphasized. The placing of arbitrary values on over 100 "by report" items was decried.

These exchanges appeared to produce some real hope of developing a revision of the *Schedule of Maximum Allowances for Medical and Related Services for the State of California* to follow more closely the 1960 *RVS*. Such revision is to be accomplished through consultation with the Committee on Fees of the CMA. An effort is to be made to adapt the legitimate needs of the State to the *RVS* without destroying its basic precepts. Because of the usual inertia surrounding such administrative changes by State agencies as well as their preoccupation with the current legislative session, these consultations are still in the planning stage. However, in view of the expressed desire of the Medical Fee Analyst to use CMA help and to achieve an accurate reflection of the *RVS* in the *Schedule of Maximum Allowances,* cautious optimism that the mechanism of determining the nature and method of services and retaining the relative value of these services will be improved eventually, seems in order.

Representatives of various State agencies administering funds for medical care programs were interviewed. Of greatest significance was the presentation by the representative of the State Department of Social Welfare who stated unequivo-

cally that it was the firm belief and policy of his Department that the level of payments for physicians' services under these programs should quite properly be placed at a level below normal fees and that approximately 80 per cent of normal was the presently accepted level. He expounded the well-known arguments of indigency, reduced payments for low-income CPS policies including State employee programs, CMA-implied acceptance of this level during the 1957 consultations and the general acceptance implied by the participation in these programs of large numbers of California physicians. Others expressed the belief that the physicians had a responsibility to service these programs regardless of the fee schedule or the regulations. The many and compelling arguments in opposition to these beliefs were presented with all the clarity and force available. The persistence and force of these administrative philosophies is pointed up by the similar testimony subsequently presented to a Senate committee by the same official and the statements of other State administrators at all levels. This firm commitment at the administrative level in all State agencies to reduced fees for the care of recipients of State assistance constitutes *the major obstacle* to achieving the usual and customary fee system.

At this meeting and subsequently, the entire mechanism of the usual and customary fee system was presented in detail to the State administrators. The medical need for retaining these patients in the mainstream of quality medical care, the normal and proper variations in fees charged within a given community and in various areas of the State, the importance of maximum physician participation, the dangers of backwash medical care and other factors involved, were all presented and tied into the concept of usual and customary fees. The State officials countered with claims of administrative complexities and the high and uncertain costs of such a system. It was obvious that administrative philosophies firmly adhered to a single, rigid fee schedule and that thoughts of departure from such single, rigid fee schedule and that thoughts of departure from such a system raised spectres of chaos in their minds. At this point, the Committee offered in exchange for provision of the usual and customary fee system to exert the full persuasive powers of the CMA to make available to the agencies the services of various review committees of the constituent county societies, and if necessary, CMA committees, to assist in making the system successful. It was pointed out that pilot programs in three areas have indicated that such a system would encourage physician cooperation to a maximum degree so that the need for the policing mechanisms so much a part of the agency thinking, would be minimal, leaving any residual problems to be adjudicated by existing and active medical society committees. The importance of such cooperation to the success of the system was emphasized. The resultant improvement in the programs themselves seemed axiomatic.

One budgetary problem raised concerned the determination of the funds needed to cover medical costs when no fixed schedule of fees can be used as the basis for budgetary estimates. The argument was advanced by us that if enough funds were available to pay a rigid fee schedule at the median level of fees, it would be actuarially possible to ignore this fixed schedule and pay the usual and customary fees since the properly determined median, by its very nature, includes these variations. Until adequate funds are made available for this level of payment, if only for a pilot study, it would be difficult to convince the agency officials on this point. Presently CPS is experimenting in this area. The Santa Barbara Plan suggests the feasibility of this actuarial approach even though this program pays at a lower level. But to repeat, until funds are available to pay the median levels, the usual and customary fees cannot be seriously considered.

In actual practice the agencies set up budgets based on a predetermined fee schedule and ask the Legislature to provide the funds to cover the aggregate of services they expect to purchase. Under the present system and in terms of Parkinson's law, any budgetary increases are usually for added services and departmental expansions, not for increased fees for services purchased. A raise in the level of fees would ordinarily require agency initiation as well as Legislative approval. Since the agencies are convinced that the present level of fees is proper, they are not likely to initiate a proposal for a higher level of fees.

Therefore, it is obvious that under existing conditions our hopes for initiation of budgets sufficient to include usual and customary fees cannot rest on agency cooperation and must rest on Legislative directives.

The possibility of covering all of the programs through the insurance mechanism was presented

and discussed. The advantages to both sides are important and this method must be considered in focus with other goals. However, when pressing for the insurance principle, we should stay within the concept of usual and customary fees, specifically avoiding any commitment to a substandard level of fees or a concept of fixed fee schedules, both of which this Committee is working to eliminate.

Later consultation was held with the Director of the Budget and the Legislative Analyst. The various points made to the lower echelon officials were re-emphasized and the possibilities of larger budgets necessary to obtain usual and customary fees were explored. Again, the discussions were frank and friendly, but little concrete hope of increases from the present composite $3.87 conversion factor level could be developed. It became increasingly evident from this meeting that any hope of establishing the basic principle of usual and customary fees for physician services and funds to accomplish this purpose lay with initiation by the Legislature. The administrators appeared willing to improve the mechanism of payment but were not motivated to seek a higher level of fees.

One encouraging development from this meeting was the agreement that the medical profession should be represented by practicing physicians on the Technical Advisory Committee to the Medical Fee Analyst so that the Analyst, in whose hands the final recommendations must lie, would have advice from both the administrators and those who must provide the services to be payed for. It appears that this change will occur. If such CMA representatives are chosen for their technical knowledge in the area of fee schedules and in the area of fee payments and administration, this type of representation at the basic level can do much to improve the mechanism of payment, if not the level of payment.

With the development of the conclusion that any hope of achieving a higher level of fees and eventually usual and customary fees lies with the Legislature and not with the administrators, a meeting was arranged with the Legislative Committee of the CMA. It was soon obvious that in the opinion of the Legislative Committee, there was no hope at this Legislative session of passage of Senate Bill No. 374, which had been introduced at the request of the CMA and which sought to amend the present legislation to include a doctrine of fees for physicians' services "commensurate with and as nearly as possible equal to the usual and customary amounts paid for such services by the public generally." In a Legislature preoccupied with the compelling problem of reapportionment, raising taxes and lowering budgets, a request for more money, no matter how justified, seemed doomed to fall on deaf ears at this time. Nevertheless, we must marshall all of our data and all of our resources for Legislative presentation at the appropriate time and in the appropriate places if we are to hope to accomplish this fundamental goal.

This Committee is grateful for the willing participation of our guests in the discussions of our problems. We are deeply indebted to the members of the CMA staff who have provided data, information and secretarial service to the Committee. The Chairman would like to thank each member of this Committee for his dedicated and thoughtful participation.

Respectfully submitted,

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